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Alcohol, Tobacco and Other Drugs

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New Zealand Quandary over Drinking Age

In 1999 New Zealand lowered its drinking age from 20 to 18, a move that was opposed by the New Zealand Medical Association. And until recently it opposed a bill which would restore the legal age to buy alcohol to 20.

But now NZMA Chair Ross Boswell, MD, says that doctors have changed their minds because their information is that there is no particular benefit for raising the drinking age. He says the problem of underage drinking should be tackled by better enforcing the law.

That flies in face of some studies that show certain alcohol-related problems have increased since the drinking age was lowered. For example, a study based on data from New Zealand, found that lowering the drinking age increases car crashes among youth *(American Journal of Public Health, Jan. 2006).*

Lead researcher Robert B. Voas, PhD, of the Pacific Institute for Research and Evaluation, said that traffic crashes by young drivers were declining in New Zealand when that country decided to lower its drinking age. Thereafter, the overall road toll for those drivers rose dramatically.

"Most remarkable was the trickle-down effect that was seen in the 15- to 17-year-olds. They're getting alcohol from older friends," said Voas.

Letter to Parents

The White House Office of National Drug Control Policy has developed a new "Open Letter" print ad that highlights actions parents can take to help their teens successfully navigate the minefield of risky behaviors during the adolescent years, including setting rules and consequences, keeping close tabs on their teens, and monitoring their teens' time on the Internet.

The Open Letter ad, signed by 16 prevention and parenting organizations, including the American Legacy Foundation, the Leadership to Keep Children Alcohol Free, and the National Campaign to Prevent Teen Pregnancy, was published in the top 25 media markets in national and local newspapers, and in select magazines.

"We're here to tell parents they are not alone. Research tells us there are some straightforward steps parents can take not only to help prevent drug use, but to reduce risk-taking across-the-board," said John Walters, director of national drug control policy. "We think parents and caregivers will find the information on how to monitor their kids practical and useful in their everyday lives."

The letter was developed by ONDCP's National Youth Anti-Drug Media Campaign. For more information go to www.mediacampaign.org

California Boasts Greatest Drop in Drug Prisoners

Proposition 36: Five Years Later, a new report from the Justice Policy Institute, says that drug treatment legislation enacted in California was followed by a greater decrease in the number of individuals incarcerated for drug possession and drug charges than any other large state prison system.

Researchers found that since 2000, among the nation's largest prison systems that track those incarcerated for drug offenses, California reduced its drug-possession prison population by the largest number (over 5,400 prisoners). California also experienced the largest numerical decline in the number of drug prisoners of the ten largest states. Only New York saw a greater percentage drop in the number of those imprisoned for drug crimes.

"Since Proposition 36 came into effect, drug imprisonment in California fell, and this has saved Californian taxpayers hundreds of millions of dollars," said Jason Ziedenberg, co-author of the report, and executive director of JPI. "In a state that has struggled with corrections and sentencing reform, Proposition 36 stands out as a successful way to reduce drug imprisonment."

Another important aspect of the research's findings was the questionable evidence of jail or incarceration serving as a deterrent to drug use or possession. The California Society of Addiction Medicine has said, "There is no evidence for the efficacy of jail sanctions." However, the report shows that jail may affect people's ability to get a job, to stay healthy, and can expose people to higher risks of communicable diseases, and increase jail costs.

Do No Harm

Every year, U.S. schools pour millions of dollars into substance-abuse education that hasn't been shown to be effective, including an estimated $750 million to $1 billion alone for DARE, or Drug Abuse Resistance Education, by far the nation's largest school-based drug-prevention program, but one that is not on federally approved lists.

But a report in the *Los Angeles Times* (May 15, 2006) says that some researchers suggest that school drug-prevention programs could do harm, particularly to younger students. Not only might they give kids a message that's so simplistic it isn't true, but the programs can also encourage kids to view themselves as potential drug users.

According to the report, they can also portray an exaggerated view of the prevalence of drugs (thereby implying use is more accepted), and, sometimes, even offer technical information that kids could use on the street.

Individually, some programs help; some hurt. And many simply haven't been scientifically studied, Liz Robertson, PhD, chief of prevention for the National Institute on Drug Abuse's research branch, told the Times.

"The harm is that kids don't need these messages yet, and by making them too simplistic, they will dismiss them when they're older and do need this message," said Robertson, adding that these programs make kids who have never considered using drugs see themselves as potential drug users.

"We know that making kids more aware can be dangerous, especially if these are high-sensation-seeking kids," she told the *Times*. "When kids are ready, they really will ask the right questions. Don't give them more information than they ask for. I don't understand people who give third-graders all the street names for drugs. Why would anyone do that?"

"Booze and Babes" Tourism Out in Catalonia

Alarmed that Barcelona's architectural landmarks and Costa Brava resorts are gaining an unsavory reputation as "booze and babes" playgrounds, authorities in the Spanish region of Catalonia are planning a summer crackdown on rowdy visitors from northern Europe.

Barcelona, long a magnet for Europeans

Continued on inside back cover

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Address letters to *Prevention File*, Silver Gate Group
P.O. Box 420878, San Diego, CA 92142-0878
Internet: tomc@silvergategroup.com
http://silvergategroup.com

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by J. Lane Designs

The Responsible Retailing

By Brad Krevor

UNDER THE AEGIS OF THE RESPONSIBLE RETAILING (RR) FORUM, public and private stakeholders are working together with researchers to validate a new model for preventing underage sales of alcohol and tobacco products. The "enforcement + assistance" model engages retailers in a quality improvement process for age-verification and ID authentication and underage sales refusal. This environmental strategy includes an important role for community and state prevention agencies.

The 1992 Synar Amendment Regulations, which were promulgated in 1996, impel states to enforce tobacco sales to minors laws. Although no federal funds were provided to assist states enforce these laws, any state that fails to achieve a graduated compliance rate (now leveled off at 80 percent) for a sampling of tobacco retailers would forfeit 40 percent of its federal substance abuse block grant. In an effort to help states achieve their Synar mandates, the Center for Substance Abuse Prevention commissioned a *Report on Best Practices for Responsible Retailing*, reflecting the experiences and insights of alcohol control boards and other state regulatory and enforcement agencies, state attorneys general, advocates and academic researchers concerning effective measures to prevent underage sales of alcohol and tobacco. Retailers and their association representatives were also members of the report committee; and the insights of these retailers, and the candid exchanges between public sector and private sector members, were significant. The principal innovations recommended by the CSAP report are:

Although enforcement is necessary, it is not sufficient to achieve and sustain the high compliance rates that communities demand.

- Identify the components of a continuing system of responsible retailing
- Establish the importance of managerial supervisory practices and accountability
- Call upon public agencies not only to enforce sales to minors laws but also to assist retailers in identifying and implementing best

Systems Project

practices for RR—an "enforcement + assistance" model (as opposed to a deterrence only model in which enforcement alone is meant to deter underage sales).

Paradox of Enforcement

Reducing underage access to commercial sources of both alcohol and tobacco products has been a public policy priority; and enforcement has been the preferred strategy to improve retailer compliance with sales-to-minors laws. Enforcement is necessary: The CSAP report describes enforcement the *sine qua non* ("without which nothing") for reducing underage sales. But the deterrent effects of enforcement have been proven to be very short-lived; and few if any states could allocate the resources to enforce sales-to-minors laws at the frequency that would be needed to sustain high compliance rates. Nor is enforcement a pedagogic tool: enforcement doesn't show retailers appropriate point-of-sales protocols for age-verification ID authentication or the proper steps for training, supervising and motivating clerks and servers to prevent future violations. Although enforcement is necessary, it is not sufficient to achieve and sustain the high compliance rates that communities demand.

A model derived from the CSAP report represents RR as an integrated, 3-tier system.

Store Level. An effective RR system has, at its core, point-of-sales protocols for verifying age and refusing sales to customers who may be underage (and/or intoxicated) and store practices for hiring, training and supervising sales clerks. The model emphasizes the role of managers in reinforcing correct age verification and sales refusal conduct through explicit store policies, employee training and performance monitoring, and their own personal conduct.

Community Level. The second tier of an integrated RR System is a community context that connects the public and private sectors in a collaborative, problem-solving approach to underage sales and use. Retailers are seen not merely as objects of enforcement who are compliant or non-compliant, but rather as

The principal goals of the RR Forum are to identify and promulgate Best Practices for RR and to engage diverse stakeholders in examinations of RR policy.

active partners with public agencies and advocates to address community-level patterns of underage acquisition and use. Additionally, the more effective retailers are in preventing underage sales, the more underage drinkers turn to "social sources"—family members, friends or even strangers who furnish or purchase alcohol for underage drinkers.

Policy Level. The third tier of an integrated RR system consists of the public policies at the state (or local) level. Penalties for underage sales by licensees and individual sellers/servers are key policies. Some states mandate RR training for store managers and/or their employees. Others create positive incentives—such as reductions in liability insurance or mitigation for violations—for establishments that engage in approved RR activities. Policies should be examined from the perspective of how effectively they encourage the adoption of effective RR practices.

Responsible Retailing Forum

The RR Forum was conceived as a way of extending the cooperation among stakeholders displayed in the development of the CSAP Report. The principal goals of the RR Forum are to identify and promulgate Best Practices for RR and to engage diverse stakeholders in examinations of RR policy. At the first RR Forum, conducted jointly in March 2003 by the Heller Graduate School, Brandeis University and the Institute of Science and Public Affairs at Florida State University, participants recommended that, as its primary programmatic goal, the RR Forum should operationalize and evaluate the "enforcement + assistance" model.

The RR Systems Project

The RR Systems model—or "enforcement + assistance" model—is being developed and tested through public-private partnerships involving state alcohol regulatory agencies, state retailer associations and the RR Forum. The particular focus of the project partners is alcohol.

The goal of Phase One (September 2003-May 2005) was to develop the tools and implementation strategies for an RR Systems model. The four study sites were Birmingham, Alabama, Des Moines, Iowa, Springfield, Missouri, and Santa Fe, New Mexico. Phase 1 developed a quality improvement tool (Planning Tool for Retailers) to assess current store practices for age verification/sales refusal at the point of sales as well as hiring, training and supervisory policies and identify best practices that may be absent.

Phase Two (September 2005-December 2006) is a community rollout of the "enforce-

ment + assistance" model. Study sites funded by the RR Forum are Montgomery, Alabama, Albuquerque, New Mexico, and Iowa City, Iowa. Similar interventions are being conducted in Waukesha, Wisconsin, and Gettysburg, Pennsylvania. In these community interventions, participating retailers assess their current RR practices, receive resources and assistance in adopting policies that may be absent, and receive periodic feedback on store performance observed by young, legal-age inspectors in Mystery Shopper visits. Phase Two also engages retailers and community stakeholders in examinations of fake IDs, third party sales (adults purchasing for an underage youth) and other social sources for alcohol. The project is also developing in-store communications to customers that address the inappropriateness of selling or furnishing youth with alcohol and ask support for clerks and servers who take the necessary time to check IDs.

The third phase (January 2007-December 2008) will address issues of system-level implementation—particularly, how can retailers be engaged in a quality improvement process? Retailers can be required to perform RR processes as a condition for holding a license, or as a condition for discharging a citation. A voluntary system would require (dis)incentives. For example, retailers who demonstrate adoption and continuous use of RR Best Practices could receive lower fees, insurance discounts, affirmative defenses, and so on. Phase Three will create experimental conditions to examine the effects of voluntary and non-voluntary policies to engage retailers in the quality improvement process. Phase Three will also examine measurement questions and performance standards: A single inspection, whether for law enforcement or quality improvement purposes, reveals the conduct of one clerk with one buyer at one moment in time; but no acceptable method currently exists for characterizing the performance of a store. Phase Three will examine measures of store performance and standards for performance.

Role of Prevention Agencies.

The "enforcement + assistance" model represents an environmental strategy to achieve retailer compliance at high enough rates to impact underage use. In Phase One, state regulatory and enforcement agencies were the drivers of the model; but retailers, we found, were very weary of working with these agencies. In Phase Two, we have added distributors as key drivers; and although the distributors are well suited to provide retailers with RR resources, they, too, are limited in their ability to recruit retailers into the quality improvement process. Too many retailers, unfortunately, are only willing to engage in an RR process after a first or subsequent citation. In Albuquerque we are discovering that community-based agencies and coalitions are critically important partners and drivers in the RR System model because the strongest reason for retailers to participate in the process is the health and safety of the communities that these retailers serve. In the RR Systems model, the regulatory/enforcement agency provides clout; private sector stakeholders like trade associations and distributors provide positive relationships and mechanisms for furnishing retailers with RR resources; but the prevention community provides the reason for retailers to make underage sales prevention a priority. ❐

Brad Krevor, PhD, is the director of the Responsible Forum, which is based at the Heller School at Brandeis University. For more information on the Forum visit cpr.fsu.edu/retail/index.html.

responsible hospitality institute

rhi NETWORK

DEVELOPING A FRAMEWORK FOR MANAGING

Part of the growth in urban population is attributed to the so-called "bookend generations" of aging "Baby Boomers" and the equal cohort of "Millennials" (those born after 1978) who want to live in an area that supports a vibrant social life.

ACROSS THE COUNTRY, CITIES CONTINUE TO EVOLVE and generate dense housing in previous commercial or retail districts, blending people of different ages, incomes, racial and ethnic backgrounds and diverse lifestyles. According to Jim Peters, president of the Responsible Hospitality Institute, this trend poses challenges as well as opportunities for businesses, government and residents alike.

Peters says that merging economic, political, and demographic forces are redefining street life in America. "Planning efforts over the last decade have steered growth toward urban areas and encouraged in-fill and redevelopment in existing neighborhoods. At the same time, there has been a renewed interest in an urban lifestyle in neighborhoods with dining and entertainment."

Part of the growth in urban population is attributed to the so-called "bookend generations" of aging "Baby Boomers" and the equal cohort of "Millennials" (those born after 1978) who want to live in an area that supports a vibrant social life. As a result, downtown and urban residential populations have increased dramatically.

"As Baby Boomers trade in their suburban houses for downtown condominiums, the Millennials are growing in numbers, coming of age and migrating to city centers. Each group seeks the convenience of travel and easy access to art, theatre, dining and entertainment. Cities are eager to comply with their desires; but the intersection of these two social generations begs the question: How do cities plan for and manage the culture clash of two distinctly different urban tribes competing for more public spaces to meet and socialize? How can cities better plan, manage and police hospitality zones?

"Opportunities for more vibrant neighborhoods challenge urban planners and business district managers as they work to stimulate tourism, re-establish street life, and enhance quality of life. Demands on public services, government licensing and enforcement agencies, as well as potential conflicts with residents on noise, trash, public safety, parking, alcohol abuse, and traffic increase simultaneously," says Peters.

To help cities meet those challenges, since 2003 the Responsible Hospitality Institute has held a series of Leadership Summits in cities throughout the United States, including Seattle, Philadelphia, San Diego, Tallahassee,

DINING AND ENTERTAINMENT DISTRICTS

Columbus (GA) and Burlington, followed by a National Summit in February 2004 in San Diego and a Networking Conference in November 2004 in Philadelphia, adding the insights from more than two dozen other cities. The purpose of these events was to examine trends and issues confronting cities relating to hospitality, safety and development.

During 2005 RHI held a series of Networking Conferences and Issue Forums and identified specific tactics used for each of the following six issue areas:

- *Entertainment Policing and Security:* Standards for security staff training, off duty officers and identify best practices of entertainment businesses and enforcement agencies.
- *Mixed Age Use Entertainment Venues:* Best practices for integrating age groups and providing space for sociability for 18-20 year olds while reducing demands on local law enforcement and risk of underage drinking.
- *Entertainment Economic Impact Assessment:* Assessing the contributions of evening and late night entertainment to local economies and the social fabric of the community.
- *Traffic/Pedestrian Safety and Entertainment:* Pedestrian flow, availability of mass transportation, taxi stands and

VIOLENCE AND ALCOHOL SALES

Stores that sell alcohol magnify violence problems in all neighborhoods where they're concentrated. The density of bars, on the other hand, intensifies violence only in communities prone to violence, while moderating violence in quieter neighborhoods, according to a new study from the Prevention Research Center in Berkeley, CA.

Researchers examined data on violence throughout California and found that the most troubled areas were poor urban neighborhoods and rural towns, places where community disorganization, poverty and residential instability were highest. In such locations, the concentration of both stores that sell alcohol and bars magnifies the communities' existing violence problems. Alcohol outlets are typically concentrated in relatively poor areas of communities.

"The regulation of alcohol outlets in violence-prone areas clearly is an important step to reducing crime," said Paul Gruenewald, PhD, scientific director at PRC and lead author of the study published in *Addiction* (May 2006). "In areas where bars are a particular problem, special effort should be made to reduce the potential for violence in these establishments."

The study showed a clear difference between the impact of stores that sell alcohol and bars in some neighborhoods. Density of stores that sell alcohol increased violence in a wide array of neighborhoods, rich and poor. A greater number of bars strongly increased violence in unstable poor and rural areas, but not in wealthy neighborhoods or established immigrant Hispanic neighborhoods.

Researchers suggested that bars in these neighborhoods could have different uses than bars in neighborhoods prone to violence. In neighborhoods with existing violence problems, bars can accelerate violence rates. But in quiet neighborhoods, they generally don't.

The new emphasis in retail, as in downtowns, is experience marketing. But before you can market the unique experience your district offers, you have to decide: Who is the experience for? Who is your market?

programs to educate service staff in licensed beverage establishments.

- *Hospitality and Diversity:* Clarifying the conflicts with cultural diversity and entertainment and how to improve relations and understanding with people with limited English proficiency opening businesses.
- *Events–Parades, Parties, Public Safety:* Events such as Mardi Gras, Saint Patrick Day, Cinco de Mayo, etc., incorporating parade, party and public safety into a comprehensive plan.

This information is being compiled into a *Practical Guide on Planning, Managing and Policing Hospitality Zones*, which will be released in December 2006 at a Leadership Summit in Chicago.

Peters encourages cities confronting the issue of expanding, multi-use entertainment areas to engage in a Hospitality Resource Partnership in their communities that brings together representatives from hospitality, safety, development and community organizations to exchange information and develop innovative strategies to enhance options for dining and entertainment.

"The new emphasis in retail, as in downtowns, is experience marketing. But before you can market the unique experience your district offers, you have to decide: Who is the experience for? Who is your market? In terms of making things happen, you also have to decide who has the right to create a district, operate in the district, make decisions about the district. Who's going to operate the programs? Provide clean streets? These decisions need to be made to create and/or maintain thriving districts. Dining and entertainment is significant to driving local economies, even as the economy stalls, and there is increasing competition among districts for consumer spending," says David Feehan, president of the International Downtown Association.

For more information on the Responsible Hospitality Institute and the Leadership Summit call 831/469-3396 or visit www.RHIweb.org.

BOOK REVIEWS

Temperance: Its History and Impact on Current and Future Alcohol Policy

By Virginia Berridge (Joseph Rowntree Foundation, November 2005. Available online at www.jrf.org.uk/bookshop/eBooks/1859354203.pdf)

"TEMPERANCE DOES NOT HAVE A POPULAR IMAGE in the early 21st century. Most people associate it with outdated attitudes, rigid moralism, narrow religion and an uncompromising attitude towards the consumption of drink. Temperance parties with no alcohol, only fruit juice and crisps do not fit well with the 21st century lifestyle. Temperance is a joke," says Virginia Berridge, PhD, in her examination of the history of temperance and how it can inform alcohol policy in the present and future.

Nevertheless, Berridge, professor of history at the London School of Hygiene and Tropical Medicine, University of London, says that in the past, temperance helped to create a 'respectable working class' and an ethos which would now be called 'social capital.' Her basic argument is that the 'real history' of temperance offers many models for the present, and that politicians, scientists and the drinks industry might do well to look at that history more closely, as some indeed are beginning to do. It also offers examples of missed opportunities which should be seriously considered.

"This nineteenth-century picture has some immediately obvious parallels with the present: a period of current concern about public disorder; the liberalization of access to drink; a culture of hard drinking across society. However, there are also differences. Society now has no mass movement focused on individual abstinence as a route to working-class respectability and advancement," says Berridge.

The report explores whether this culture can be brought up to date. It also discusses the role of the media, of pressure groups and of local government, the prominence given to women's drinking, the potential for religious influence in a multi cultural society, health messages about alcohol, and alliances between medicine, public health and the police. It also reviews the political possibilities for alcohol.

"For the first time for many years alcohol is a political issue, as was temperance," says Berridge. The report looks at whether those with an interest in health should work with the drinks industry, explores the role of international networks of influence and considers how the history of action against tobacco can inform future alcohol strategies.

Berridge concludes that the history of temperance offers many options for the present. It will appeal to all interested in alcohol issues and the development of policy.

"So the past offers plenty of food for thought for the present. This report argues that the history of temperance is relevant to current and future policy at three levels:

- The current debates often unwittingly reuse arguments and take positions which come from temperance and the drink issue of the nineteenth century. The following concerns all echo nineteenth and early twentieth-century debates: crime and disorder; out-of-control women; and whether alcohol use is good for you or not.
- There are missed opportunities in the present because the real history of temperance is forgotten or misused. For example: the role of women could be used more positively; religion could also be built on in a multicultural society; there are potential alliances between medical and scientific and criminal justice interests; and there are opportunities for wider democratic involvement offered by licensing reform.
- Temperance itself and its political and scientific supporters missed strategic opportunities in history or failed to achieve certain aims. These are now again on the agenda. Issues here are the enhanced role for local government in licensing, the political possibilities in the drink issue and the potential for working with sections of the industry.

"History does not repeat itself, but we can see similarities between the early twenty-first century and the 1830s, the period of free trade and beerhouse expansion. This led to the huge growth of temperance, of sentiment which was deeply critical of the results of free trade. Temperance cannot be revived in its nineteenth century version, but there are opportunities and policy options in the present situation which its history throws sharply into focus," says Berridge.

BOOK REVIEWS

When They Drink: Practitioner Views and Lessons Learned on Preventing High-Risk Collegiate Drinking

Edited by Robert J. Chapman (Rowan University, March 2006. Available online at www.rowan.edu/cas/cas/documents/draftmanuscript_000.pdf)

IN HIS PROLOGUE to *When They Drink: Practitioner Views and Lessons Learned on Preventing High-Risk Collegiate Drinking*, Robert Chapman, PhD, counselor educator at La Salle University, says that to "change the campus drinking culture" has become something of a rallying cry for those involved in higher education. But for the first time, there are models for accomplishing this objective that hold promise.

"The programs that hold promise are not steeped in legislative responses or enacted by those long out of college. Neither are they programs that attempt to simply educate students about the risks and dangers of alcohol abuse with the expectation that information alone will lead contemporary collegians out of harms way," says Chapman. Rather, contemporary prevention strategies are steeped in evidenced-based approaches.

"These tactics offer approaches designed to meet students in each of three specific collegiate subpopulations, each with its own idiosyncratic characteristics: the universal or general student population, the selective or at-risk student population and, the indicated or already-showing-signs-of-a-problem student population," says Chapman.

"Well-crafted policy and procedures can help bring all members of the campus culture—students, staff, faculty, and parents alike—to a point where they are willing to consider the possibility that change results from acting on the issue of collegiate drinking rather that reacting to it. It is this call to action that is the focus of this collection of essays," says Chapman.

When They Drink is organized into three sections. Part I includes professional essays related to best practices and contemporary thinking on the topic of understanding, preventing, and/or intervening with high-risk collegiate drinking. Part II includes personal essays that present a practitioner's view on "Lessons Learned" written by prevention specialists, senior administrators, community activists, professional counselors and educators. Appendix A is a collection of essays, used with the permission of the U.S. Department of Education's Higher Education Center for Alcohol and Other Drug and Violence Prevention and taken from a previously unpublished edition of the newsletter *Catalyst*

For example, in "Substance Use on Campus: A Brief History" Richard Lucey, Jr., an education program specialist with the U.S. Department of Education's Office of Safe and Drug-Free Schools, says, "Since the Colonial Era, colleges and universities in America have had to address the issue of students using psychoactive substances, especially alcohol, on campus. Perhaps the heart of this matter can be found in alcohol's seeming omnipresence in the hallowed halls of higher education." His essay chronicles that presence.

Other selected essays are "Organizing a Community Coalition: Lessons Learned from Lincoln, Nebraska," by Thomas Workman, PhD, and Linda Major, University of Nebraska-Lincoln; "How Public Alcohol Policy Shapes Prevention," by George Dowdall, PhD, Saint Joseph's University; "Fences May Make Good Neighbors, but Not in Prevention: My Experience in an On-going Collaboration to Address Dangerous Drinking on the College Campus," by Linda Lederman, PhD, University of Arizona.

All-in-all the 30 essays and articles in *When They Drink* provide a comprehensive overview of research and practice in addressing drinking by college students that would assist those working in campuses and surrounding communities understand the issues and condition that contribute to problems and develop strategies for prevention. ❐

Treating the Alcohol Industry as a Pariah is a Losing Proposition

by William DeJong

IN THE 1970 FILM "LITTLE BIG MAN," Jack Crabb, a white man raised since boyhood by the Cheyenne, presents himself to General George Armstrong Custer, hoping to be taken on as a scout. The two men have a history. Crabb once planned to assassinate Custer, whose men had shot and killed Crabb's Indian wife and their baby during a raid, but he lost his nerve at the last moment. Custer spared his life and banished him, stating that Crabb would find living with his lack of courage to be a greater punishment than execution.

Now, after months in desperate exile, Crabb has come back to Custer, hoping to find another way to exact his revenge. The General, portrayed here as a flamboyant narcissist, blithely agrees to bring Crabb on. With his second in command expressing incredulity, Custer condescendingly explains his thinking about Crabb: "Anything that man tells me will be a lie. Therefore, he will be a perfect reverse barometer."

Crabb now knows that he has Custer where he wants him, because the General has stopped thinking for himself. No matter what Crabb says, Custer will do the opposite, and, as the film would have it, this is precisely what leads the General to his doom at Little Big Horn.

Seeing the Alcohol Industry as Evil

Many prevention advocates have come to distrust the alcohol industry as much as General Custer distrusted Jack Crabb. The industry is evil, the thinking goes, and therefore any prevention measure their representatives support must be viewed with suspicion and rejected.

It's easy to understand why prevention advocates might come to demonize the alcohol industry as an archenemy. Breweries, wineries, and distillers make a lot of money, and they have used it to buy a policy environment that protects their profits at the expense of research-based prevention practices. Moreover, these businesses run product advertising that appeals to kids and problem drinkers, who together are responsible for an unconscionable share of the industry's revenues.

Taking their anti-industry stance to an extreme, some advocates now regard the alcohol industry as a "reverse barometer." If the industry favors a certain program, their thinking goes, then it must be a bad idea. And if it seems at first like it might be a good idea, then advocates obviously haven't given it enough thought to discern the industry's devious purpose.

Going even further, some prevention advocates attack ideas they don't like by charging

Alcohol prevention advocates have had their own experiences with the alcohol industry. For years, we have watched the industry pump out so-called "responsible drinking" advertising, vague messages that fail to provide useful prevention information, yet provide effective political cover to sidetrack other prevention measures, all the while promoting their brand names.

that proponents are doing the industry's bidding, as if that settles the matter. For example, there are legitimate scientific reasons for questioning the use of the term "binge drinking" to describe heavy, episodic drinking, yet in his book *Dying to Drink,* Henry Wechsler defended his use of the term, not by arguing the merits of his case, but by reproving his detractors as dupes of "Big Alcohol."

Wechsler similarly attacked proponents of social norms marketing campaigns, which are designed to reduce college alcohol consumption by correcting exaggerated misperceptions of student drinking norms. True, the alcohol industry has provided financial support for a small number of campaigns, but this campus-based program was first developed and tested with no industry funding whatsoever. Ultimately, only rigorous scientific study can determine whether social norms campaigns are worthwhile, but as the evaluations were being done, Wechsler cast out the program as the industry's evil spawn and even chided the federal government agencies that supported the research.

Even speaking at an industry-sponsored event can be viewed as taboo. When I directed the Higher Education Center for Alcohol and Other Drug Prevention, I received an invitation from the Distilled Spirits Industry Council of the United States (DISCUS) to speak at their American Campus and Alcohol Conference in 2000. I accepted no money from DISCUS, not even a travel reimbursement, yet representatives from the Robert Wood Johnson Foundation, who provided ancillary support for the Center, expressed alarm that I would be speaking at the conference and demanded an explanation. How could I lend my "good name" to this industry event?

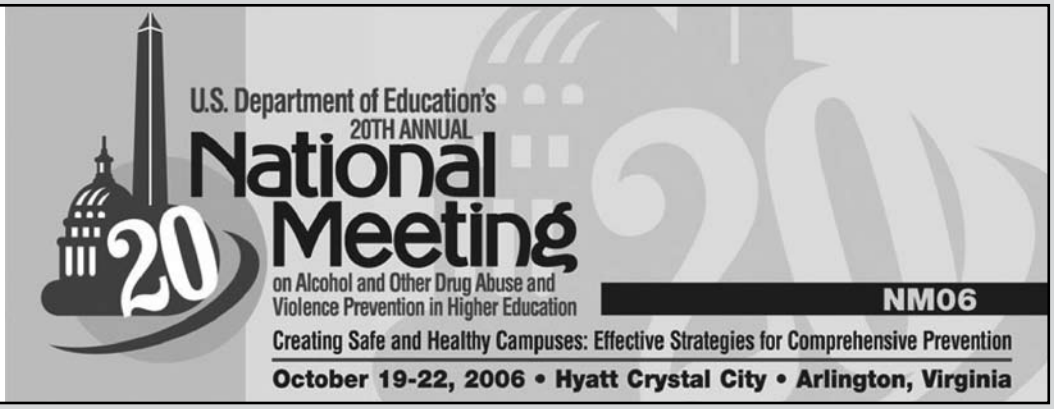
In fact, I was taking advantage of a natural opportunity for collaboration. DISCUS had assembled 34 campus-community teams, which included 29 college and university presidents. Each campus was promised a $10,000 stipend from DISCUS to supplement its prevention work, and I relished the prospect of influencing what they did with those funds. This was an ideal occasion for me to talk about environmental management and the possibility of campus and community leaders working out negotiated agreements with local alcohol retailers to eliminate low-price promotions.

Being Cautious to a Fault

How prevention advocates view the alcohol industry is shaped by the experiences of tobacco control advocates. There is no doubt that the public health community has made enormous progress in fighting the tobacco industry, but there's also a prevailing sense that the industry's well-paid business planners and public

The U.S. Department of Education will convene its 20th Annual National Meeting on Alcohol and Other Drug Abuse and Violence Prevention in Higher Education and the National Forum for Senior Administrators on October 19 – 22, 2006, at the Hyatt Regency Crystal City hotel in Arlington, Virginia.

For more information please visit www.higheredcenter.org/natl/2006/



relations flacks are always a step or two ahead. Hard-won gains such as the federal ban on broadcast advertising and mandatory cigarette warning labels were turned to the industry's advantage by providing a preemptive defense against state regulation or by protecting tobacco companies against civil suits charging them with deceiving the public.

Alcohol prevention advocates have had their own experiences with the alcohol industry. For years, we have watched the industry pump out so-called "responsible drinking" advertising, vague messages that fail to provide useful prevention information, yet provide effective political cover to sidetrack other prevention measures, all the while promoting their brand names. Advocates have also watched the industry support various art and cultural groups, which they then use to increase brand recognition and to earn community goodwill ("innocence by association," some advocates have called this). Along with many other advocates, I have long warned that accepting industry contributions can ultimately result in pressure to oppose alcohol control measures that the industry might find objectionable.

I agree that there is reason to be guarded when the alcohol industry favors a particular proposal. But I also think this caution can be taken to an unhealthy extreme. Using the industry as a "reverse barometer" short-circuits our own thinking and can prevent us from taking advantage of opportunities where cooperation can pay off in reduced alcohol-related problems.

Pursuing an Independent Agenda

As prevention advocates, we need to set our own agenda, grounded in science and sound public health practice. We shouldn't let the industry's viewpoint dictate what we do or do not support. For example, the Century Council came out in favor of lowering the per se limit that defines alcohol-impaired driving to .08 percent BAC (blood alcohol content). Did that make this policy a bad idea? Of course not. The Century Council had its own reasons for supporting this policy, but in this case the science was clear. Even so, some prevention advocates criticized MADD for acknowledging and thanking the Century Council for its support. This is foolishness. We have to get past the idea that anything that brings credit to the industry is inherently bad.

Consider responsible beverage service (RBS). As part of the Community Trials Project, Robert Saltz and Paula Stanghetta, of the Prevention Research Center in Berkeley, found that owners and managers of local bars, taverns, and restaurants in three sites across California and South Carolina supported principles of RBS, which includes service policies to prevent sales to underage and intoxicated patrons, management and server training, and effective staff monitoring systems. Properly employed, an RBS program can reduce levels of impairment among an establishment's patrons. Do such programs bring credit to the alcohol industry? Yes. Should they still a priority for prevention advocates? Yes. Should we collaborate with the industry to develop and maintain effective RBS programs? Of course.

Treating the alcohol industry as a pariah is a losing proposition, both politically and strategically. Where it makes sense to collaborate, we should do so. But we should take that step while being clear that when the alcohol industry opposes science-based prevention—by trying to undermine support for the age 21 minimum drinking age laws, by opposing reasonable excise tax increases, or by using irresponsible advertising that appeals to underage and problem drinkers—we will fight them in the court of public opinion and we will prevail. ❐

William DeJong, PhD, is a professor of social and behavioral sciences at the Boston University School of Public Health and a senior advisor to the Center for College Health and Safety at Education Development Center, Inc., in Newton, MA.

ALCOHOL INDUSTRY UNDER FIRE—AGAIN

PUBLIC HEALTH ADVOCATES HAVE LONG CRITICIZED THE ALCOHOL INDUSTRY for marketing and promoting its products to underage drinkers. While spokespeople for alcohol producers routinely deny targeting underage drinkers, a new study now shows just how important that market is to industry profits.

A recent study from the National Center on Addiction and Substance Abuse at Columbia University, "The Commercial Value of Underage and Pathological Drinking to the Alcohol Industry" (*Archives of Pediatrics and Adolescent Medicine,* May 1, 2006), says that in 2001 at least $22.5 billion of consumer spending on alcohol came from underage drinking. Another $25.8 billion came from adult pathological drinking—those that meet the American Psychiatric Association's "clinical criteria" for dependency.

"Consuming at least $48 billion in beer, wine and liquor, underage and pathological drinkers are the alcohol industry's most valuable customers," said Joseph A. Califano, Jr., CASA's chairman and president and former U.S. Secretary of Health, Education and Welfare. "It is reckless for our society to rely on an industry with such an enormous financial interest in alcohol consumption by children, teens, alcoholics and alcohol abusers to curb such drinking. Self regulation by the alcohol industry is a delusion that ensnares too many children and teens."

Commenting on the study, George Hacker, JD, alcohol policies project director at the Center for Science in the Public Interest, said: "It should come as no surprise that an industry that derives nearly $50 billion in revenues from underage and adult pathological drinking has opposed almost every major public health measure designed to reduce alcohol problems, and that it has attempted to cover its tracks by preaching personal and parental responsibility in a myriad of ineffective education programs that smack more of public relations than serious prevention."

Lead author of the study, Susan E. Foster, vice president and director of policy research and analysis at the Center, said the findings show that the "federal government needs to regulate the alcohol industry and that there should be a major public-health campaign," involving parents, schools and doctors, that is focused on underage drinking.

"There is a very strong link between underage drinking and pathological drinking . . . so the commercial interests of the alcohol industry directly conflict with the public health," said Foster.

Jeff Becker, president of the Beer Institute, told *The Washington Times* (May 2, 2006) that brewers are adamantly opposed to underage drinking and abusive alcohol consumption and cited a 2003 National Academy of Sciences report that showed most underage drinkers get alcohol from "noncommercial sources," such as parents and older siblings.

"Over the past two decades, our members have invested more than $50 million a year on prevention programs that help parents talk to their children about this very serious issue," Becker said.

And Peter Cressy, of the Distilled Spirits Council, told the Scripps Howard News Service that the spirits industry is "vehemently opposed" to underage drinking and has worked to combat the problem.

However, former U.S. Surgeons General

There is a very strong link between underage drinking and pathological drinking . . . so the commercial interests of the alcohol industry directly conflict with the public health.

ALCOPOPS—BEVERAGE OF CHOICE FOR KID?

Alcopops—alcohol masquerading as soft drinks—have drawn fire from public health advocates and parents alike since their introduction in the mid-1990s because of their appeal to teens. The term is a combination of "alcohol" and "pop." Classic alcopops are alcoholic versions of soft drinks that are characterized by fizziness, artificial coloring, sweetness and sale by in single-serving bottles.

Testifying in San Diego at a March 11, 2006 public hearing of California's Senate Select Committee on Children, Youth and Families, David Jernigan, PhD, of the Center on Alcohol Marketing a Youth, said "It's a growing problem. About seven million American kids 21 and younger admit to being binge drinkers, and every day 5,400 youths age 16 and younger take their first drink of alcohol."

Jernigan said that 23 percent of television commercials for alcohol are placed during programs in which kids make up more than 15 percent of the audience. "It would be very simple to move the advertising to places where kids are less likely to see it."

The California-based California Coalition on Alcopops and Youth is taking action aimed at containing the growing problem of underage drinking, in general and specifically alcopops. The Coalition, whose members include the California Prevention Collaborative and the California Council on Alcohol Policy, among others, is spearheading an advocacy campaign that uses litigation, media, research, and legislation to raise awareness of underage drinking and the role that advertising and marketing play in contributing to the problem.

In fact, the coalition worked closely on a bill to restrict marketing of alcoholic beverages to underage drinkers (SB1180). But, according to an editorial in the *San Francisco Chronicle* (April 19, 2006), lobbying by the alcohol industry helped prevent a bill "from gaining traction in Sacramento. So state Sen. Carole Migden, D-San Francisco, the bill's author, revised it to call on the state to conduct a study of the problem by January 2008."

NOT JUST A PROBLEM OF YOUNG PEOPLE

Cutting drug use by youths is the predominant focus of prevention efforts—and spending—in the United States. But as progress has been made in reducing teen drug use, more middle-aged Americans are dying of drug overdoses, according to a recent report in *Psychiatric Times* (April 2006). It says that the typical addict is likely to be in their mid-30s to mid-50s, but that prevention programs often overlook Baby Boomers.

"There is a generational bias going on," said sociologist Mike Males, PhD, of the University of California, Santa Cruz, in the report. "Of 3,700 drug deaths in California during 2003, only 51 were [in people] under the age of 20." Males said: "The authorities have refused to deal with this issue. I think there are several reasons for this: For one, the war on drugs historically has gone after out-groups—minorities, immigrants, youth. We are unable, for political reasons, to deal with drug abuse problems among mainstream populations."

Older drug users also predominate in emergency-room visits, according to the federal Drug Abuse Warning Network. "I'm surprised the numbers have escaped attention this long," said Males. "How did it get to the level it did with no notice? It's really a remarkable information breakdown. These numbers are not generally picked up in the popular press. People usually look for the heart-wrenching stories, the young person who lost his or her chance at life. Emergency-room doctors and counselors are well aware of the older sector of drug users."

Julius Richmond (President Carter), Antonia Novello (President George H. W. Bush), and David Satcher (Presidents Clinton and George W. Bush) have called for federal regulation of the alcohol industry's advertising and marketing practices. In a joint statement they said: "If unchecked, the alcohol industry stands to gain at least one-half trillion dollars in cash revenues over the next decade from consumption by underage and pathological drinkers. The industry's significant financial gains from underage and pathological consumers create a conflict of interest for the alcohol industry. This conflict is so substantial that regulation of advertising and marketing practices solely by the industry cannot be expected to work."

Other findings from the CASA report are:

- Alcohol abuse and addiction cost the nation an estimated $220 billion in 2005—more than cancer ($196 billion) and obesity ($133 billion).
- Each day more than 13,000 children and teens take their first drink.
- Children and teens that begin drinking before age 15 are four times likelier to become alcohol dependent than those who do not drink before age 21.

Califano urged parents, colleges and the media, as well as alcohol industry executives to accept personal responsibility to help curb underage and pathological drinking as follows:

- Parents are children's first line of defense and should be actively engaged in their children's lives. They should restrict availability of alcohol to their children and talk to their children about the dangers of alcohol abuse and addiction.
- Colleges must accept their responsibility to create environments that discourage drinking, including the prohibition of alcohol advertising on campus and at sponsored events. The National Collegiate Athletic Association (NCAA) should ban all beer and other alcohol advertising during broadcasts of college sporting events like football and basketball games
- The media, including magazines, network and local radio, television and cable stations, and Internet sites should take steps to avoid exposing underage viewers to alcohol advertisements. ❐

For more information on The Commercial Value of Underage and Pathological Drinking to the Alcohol Industry *go to www.casacolumbia.org.*

Emergency Departments May be the Perfect Setting to Reach At-Risk Drinkers.

REALIZING THAT NEARLY HALF OF THEIR TRAUMA PATIENTS were due to at-risk or hazardous alcohol drinking, many emergency departments are adopting brief motivational interventions to change behavior to prevent ever seeing these patients at their doors again with life-threatening injuries due to alcohol use.

In 2000, the National Center for Injury Prevention and Control reported that an estimated 20.5 million adult injuries require emergency department treatment and that alcohol abuse and dependence are the leading causes of injury in the United States.

The Journal of the American Medical Association (February 2003) reported that 45 percent of patients admitted to trauma centers are alcohol intoxicated and are 2.5 times more likely than non-intoxicated patients to be readmitted for a future injury.

Clearly, alcohol is a contributing factor in many people's visits to the emergency department. And even more clearly is the need to do something about it. For more than a decade, brief interventions have been used to help at-risk alcohol users reduce their drinking habits to non-risk levels. Brief interventions typically do not target patients who are alcohol dependent, although they sometimes are used to motivate them to seek more intensive alcohol-related treatment.

Clearly, alcohol is a contributing factor in many people's visits to the emergency department. And even more clearly is the need to do something about it

The techniques used for brief interventions were adopted from motivational enhancement therapy or motivational interviewing that was first introduced in 1989 by William Miller, PhD, professor of psychology and psychiatry at the University of Oregon. The underlying idea behind motivational interviewing is that the responsibility and capacity for change rests with the patient. The person doing the interviewing provides feedback about the effects of the patient's drinking and then together they explore the benefits of abstinence or drinking at safe levels, review treatment options, and design a plan to implement treatment goals. These could include numerous follow-up sessions with a therapist.

Alternatively, brief interventions are typically

AT-RISK DRINKING DEFINED

At-risk or hazardous drinking is when a person drinks beyond the recommended limits and is then vulnerable to injury, illness, or social and legal problems. The Dietary Guidelines for Americans 2005 promulgated by the U.S. Department of Health and Human Services and Department of Agriculture say:

- Those who choose to drink alcoholic beverages should do so sensibly and in moderation—defined as the consumption of up to one drink per day for women and up to two drinks per day for men.
- Alcoholic beverages should not be consumed by some individuals, including those who cannot restrict their alcohol intake, women of childbearing age who may become pregnant, pregnant and lactating women, children and adolescents, individuals taking medications that can interact with alcohol, and those with specific medical conditions.
- Alcoholic beverages should be avoided by individuals engaging in activities that require attention, skill, or coordination, such as driving or operating machinery.

one-time events (with the exception of perhaps a follow-up phone call or follow-up with a patient's personal health care provider) that last from 10 to 60 minutes and are designed to encourage at-risk drinking patients to limit their drinking to low-risk levels to reduce their risk for illness or injury.

Unique Opportunity

While the interventions are brief, the emergency department is an opportune environment for such interventions because patients are more open to discussing change after experiencing some level of trauma. Larry M. Gentilello, MD, professor of surgery at the University of Texas, Southwestern Medical School and an investigator on a number of studies on brief interventions found that there was a teachable moment for patients who have had a life-changing experience were receptive to doing something about their alcohol problem.

"While in most other situations in which counselors would have to sell patients on the idea of doing something about their alcohol problem, they did not have to sell trauma patients at all. They were very receptive. We got 87 percent of patients we approached into alcohol treatment," Gentilello said.

A randomized clinical trial Gentilello conducted in 1993 in Seattle showed that screening patients for alcohol intoxication in the trauma center or emergency department, followed by a brief intervention by an alcohol counselor for those with a positive screening, reduced alcohol consumption. Patients had 47 percent fewer re-admissions than the control group, and the intervention reduced re-injury rates by one-half.

The Nuts and Bolts

The techniques and length of time spent for interventions vary, but the ultimate goal is to help at-risk alcohol users realize on their own the need to change and then to decide what they are willing to do to cut back on their drinking. The interventions are given to people who have first been screened for at-risk drinking. Surprisingly, most patients are forthcoming and willing to discuss their alcohol patterns with health practitioners. The interventions, says Linda Degutis, PhD, associate professor of surgery (emergency medicine) and public health at Yale School of Medicine and associate research director for the Section of Emergency Medicine, involves four steps:

- *Establish rapport and raise the subject or alcohol use.* This step includes talking about the patient's pattern of alcohol use and why he or she may be at risk.
- *Provide Feedback*. Here you review the patient's drinking amounts and patterns. You might also make the connection between their injury or health consequences and their alcohol use, said Degutis. "For example, with a person who has fallen down the stairs, you might say 'do you see the connection between your alcohol use and falling down the stairs? And you might reinforce that by saying that the alcohol can slow your reflexes and reduce your response to prevent falling when you trip."
- *Enhance Motivation*. This involves assessing a person's readiness to change and discussing the pros and cons of drinking. It may involve having patients gauge their readiness to change using a 1 to 10 scale, with 1 being

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not ready to change to 10 extremely ready to change. "If they say '4,' says Degutis, you might ask them why they didn't say a '2' and then discuss the areas in which they are ready to change." At this staff, you provide positive feedback concerning their willingness to make the changes discussed.

- *Negotiate and Advise*. At this step, the interviewer talks about the next steps to take and advises a patient on safe levels of drinking and both come to an agreement of what the patient is comfortable doing. The patient is also asked to fill a drinking agreement outlining his or her goals for change.

Overcoming Barriers

Even with the mounting positive evidence, anyone interested in implementing a brief intervention program in their emergency department may face some common barriers. One of the major deterrents to screening and intervention in the ED is time. With busy EDs and limited staff, many practitioners feel that they don't have the time to spend screening and providing an intervention.

"Many people on the front line—physicians, nurses—are concerned that it will take too much time and that it isn't worth their time because they aren't aware of how effective these interventions are," said Katherine McQueen, MD, medical director of Insight, the State of Texas Screening Brief Intervention and Referral to Treatment Program serving the Harris County Hospital District.

Another barrier is cost. "A big problem is financing the interventions," said Robert Woolard, MD, chairman of the Department of Emergency Medicine of Rhode Island Hospital who has conducted research on brief intervention for more than a decade. Someone will have to pay for it, even though the research indicates that in the long run the interventions will save money.

It may not be long before the cost benefits can be ignored as more studies are conducted to show the relation between the interventions and the bottom line on health care costs. An estimated $1.82 billion in U.S. health costs could be saved if all patients who receive treatment for injuries in emergency rooms or trauma centers were screened for alcohol abuse and received a brief counseling intervention, if needed, according to a study conducted by researchers at the University of Washington (Seattle) School of Medicine.

Authors of a 2002 study ("Brief physician advice for problem drinkers: Long-term efficacy and benefit-cost analysis," *Alcoholism: Clinical and Experimental Research*) found that their interventions, which cost $205 per patient, saved $712 in medical costs, $201 in legal costs, and $7,171 in motor vehicle accident costs for each

BRIEF INTERVENTION DON'TS

Motivational interviewing is designed to establish rapport with patients and help them realize the benefits of changing their behavior and to set their own goals for change. Practitioners should not:

- argue that the person has a problem and needs to change
- offer direct advice or prescribe solutions to the problem without the person's permission or without actively encouraging the person to make his or her own choices
- use an authoritative/expert stance leaving the client in a passive role
- do most of the talking
- impose a diagnostic label
- behave in a punitive or coercive manner.

patient. The net benefit-cost ratio they found was 39 to 1.

Of course, costs for the intervention vary depending on who conducts it. Naturally, the costs are higher if the physician provides the intervention. But many hospitals use graduate students and some use high school graduates who have received training and monitoring before being allowed to conduct the interventions on their own. It is important to remember that people need to be trained in conducting these interventions correctly. And the cost for training could pose another barrier.

Other low-cost options being explored include using technology to provide the intervention. McQueen and others are looking at using computerized kiosks in ED waiting rooms. Such technology has its benefits. Computer programs can screen patients for at-risk behavior and may elicit more honest disclosure of a problem and provide tailored information. And computerized self-assessment eliminates the need for using time-starved staff to provide the intervention.

Another barrier that is a problem in some states are legal concerns. A 1947 law that was adopted by 42 states penalizes surgeons who screen patients for alcohol use. The Uniform Accident and Sickness Policy Provision Law allows insurance companies to deny payment if the trauma or emergency physician documents that the injured patient has alcohol in their system. Of course, surgeons rarely test a critically injured patient for their blood alcohol content and report it so that insurance companies can refuse payment. But it could discourage them from screening a patient for alcohol use.

"No wonder most trauma surgeons do not screen patients for alcohol use. If the doctor doesn't document that the patient is intoxicated, the insurer usually has no other way of finding out, so they are currently paying for treatment of almost all alcohol-related injuries anyway. They just don't know it. But, patients and society lose because by sweeping the problem under the rug, we miss the opportunity to provide an intervention," said Gentilello.
A recent survey of trauma surgeons, says Gentilello, documented that 82 percent would be willing to start a screening and intervention program if the insurance obstacles were removed.

Removing these barriers will be easier as laws are changed and as people are converted as evidence of the efficacy of reducing injury and readmission rates in the ED and the cost-benefit ratio continues to grow. McQueen says that mounting evidence is one of the reasons that the American College of Surgeons has changed their certification guidelines to require level one trauma centers to have a screening and intervention program in place by 2007. Level two trauma units will have to have at least a screening program in place.

Changing attitudes may involve getting key people converted, says McQueen. She says it may take working with influential people in the ED and sharing the available evidence and successes of patients who have been screened and taken part in an intervention to get more people involved.

"We have to convince those working in hospitals," said McQueen, "that [brief interventions] are not only good for the patient but for an overloaded trauma system as well and if we can reduce trauma through these interventions then it is good for the health care system and the community."

Continued from inside front cover

for its beauty, its cuisine and its free-and-easy Mediterranean lifestyle, has become a favorite destination for hard-drinking "stag and hen-night" crowds and college graduation parties.

According to *The Independent* (March 28, 2006) last summer British, German and Dutch tourists invaded Catalonia's beach resorts and handsome urban squares, and outraged locals with their noisy, all-night partying, sexual promiscuity and uncontrolled vomiting in Gothic passageways and Art Nouveau doorsteps.

Fed up, the Barcelona town hall and the Catalan regional government, have drawn up a battery of measures to stamp out anti-social—what they call "uncivil"—behavior.

The Catalan government will crack down on dozens of websites containing "illegal" ads. The region's interior minister, Montserrat Tura, knows it will be difficult to act against foreign advertisers, often private individuals seeking to organize group visits on the cheap.

In addition, the authorities have banned street vendors, skateboarders, jugglers, bongo-drummers, DVD sellers, windscreen-cleaners, beggars, graffiti artists, clients soliciting prostitutes in the street, and anyone drinking in public squares, or dressed indecorously, or urinating in public.

Barcelona's socialist mayor, Joan Clos, considers his measures against uncivilized behavior "a priority," and promises to step up implementation as the tourist season approaches.

Smoking Ban in Scotland

Scotland now bans smoking in thousands of pubs, clubs and cafes—the first such action in the United Kingdom. England and Wales will follow next year.

The ban also applies to the Parliament building in Edinburgh and in palaces. And smoking has also been made illegal in places of work, including lorries and vans, theatres, airports, art galleries, railway stations and shopping centers. In addition, local Councils have the power to ban the habit at school gates and other places where children gather.

"Scotland will be proud that it has gone smoke-free ahead of any other part of the UK. The smoking ban is absolutely the right way forward. It is right for Scotland, for our nation's health, our nation's economy and our tourist industry," said First Minister Jack McConnell.

Under the Influence—At Work

According to a report in the *Journal of Studies on Alcohol* (Jan. 2006), an estimated 19.2 million U.S. workers (15.3 percent) reported using or being impaired by alcohol at work at least once in the past year. The most common alcohol-related workplace behaviors were being hungover at work (9.2 percent) and using alcohol during the workday (7.1 percent), primarily during lunch breaks.

Despite the relative magnitude of the problem, most workplace alcohol use or impairment occurred infrequently—70 percent of workers reported using or being impaired by alcohol on a less than monthly basis, 19 percent reported it on a monthly basis, and 11 percent reported doing so weekly.

Researcher Michael R. Frone, PhD, of the University of Buffalo, said that "the prevalence of alcohol use and impairment in the workplace was sufficiently high to suggest that employers need specific policies directed at alcohol use and impairment at work and employees need to be aware of these policies."

Silver Gate Group
PO Box 420878
San Diego, CA 92142-0878

Ten Years Ago in *Prevention File* (Vol. 11, No. 2, Summer 1996)

WHEN IS A BINGE A BINGE?

THE HEADLINE TELLS THE STORY: Binge drinking rampant on campus. Some readers are sure to envision the kind of prolonged drinking bouts they've seen in the movies—from *The Lost Weekend* to *Leaving Las Vegas*.

But that isn't what the newspaper is referring to.

The story under the headline reports on a survey of college drinking habits. A hefty percentage of students say they have downed five or more drinks—cans of beer, shots of whiskey, or glasses of wine—on a single occasion in the last two weeks.

Therein lies the grounds for a debate being heard in the corridors of alcohol research institutions. "Binge" has become a handy term in the survey literature to describe a level of drinking that some believe is the dividing line between harmless and harmful–five drinks at a sitting for men, four drinks at a time for women. Research papers using the term "binge-drinking" generally specify that this is what they mean. What they mean and what readers understand may differ, however. Is this an appropriate use of "binge" when the word has a different meaning in the popular mind?

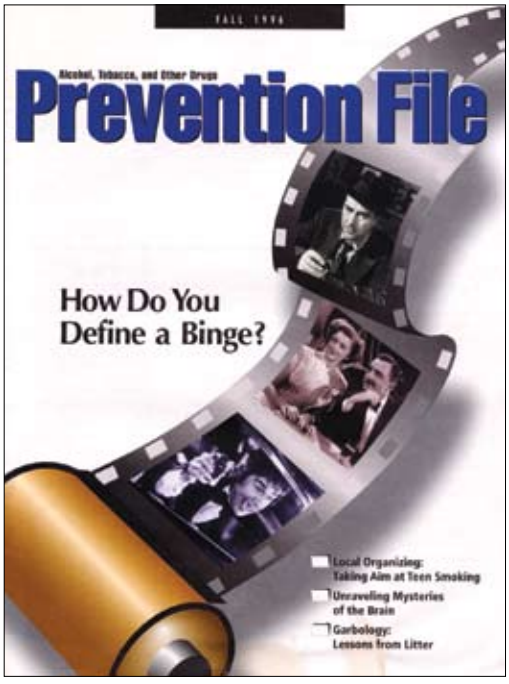
"Binge" dates back a century or so in the lexicon of drinking. The word was associated originally with building boats or wooden vats, which were "binged", or soaked in order to expand the joints and make them waterproof. Around the mid-19th century, according to the Oxford English Dictionary, "binge" was beginning to be heard as both a verb to describe heavy drinking and now to refer to a drinking bout.

Throughout the 20th century, it has been a workhorse in speech and literature where the subject is drinking. American dictionaries define "binge" in no uncertain terms: "a drunken celebration or spree," "a riotous indulgence," "an uninhibited and usually excessive indulgence, especially in alcoholic beverages." Webster's Third International cites as possible synonyms: orgy, rampage, splurge. Stuart Berg Flexner, in his book on spoken American English (*I Hear America Talking*), adds "bat" and "toot" as words used interchangeably with "binge".

Binge-drinking as the term for five or- more drinks at a sitting owes much of its currency in research literature to the work of Henry Wechsler, PhD, of the Harvard School of Public Health. His studies of drinking on college campuses have relied on the term as a benchmark. For Wechsler, five drinks on a single occasion for men and four for women is a threshold of trouble. Nevertheless, in a recent article published in the *Journal of Studies on Alcohol,* he was asked by his editor to avoid references to "binge-drinking." The article instead referred to five drinks or more (and four for women) as "episodic heavy drinking."

Robin Room, PhD, director of the Addiction Research Foundation in Toronto and a veteran of alcohol studies for more than 30 years, believes the use of "binge" as a five drink benchmark may be an example of "problem amplification" in the field. A new research finding or new terminology is seized upon and popularized less because of its importance that its power to dramatize a problem. The use of "binge" to describe a certain level of drinking may have gained wider use because it tends to arouse concern command less attention.

The Addiction Research Foundation avoids use of "binge" in the five-drinks-or-more context, Room said. He pointed out, however, that finding a better term is not easy. "This has been a problem as long as I've been in the research field. If we say "heavy drinking," what exactly do we mean?"



Editor's note: The term "binge" remains both common and controversial, especially when it is applied to college students. In a commentary in Prevention File (Spring 2004) William DeJong, PhD, a professor in the Department of Social and Behavioral Sciences at the Boston University School of Public Health, said that "on the downside, this term creates an exaggerated view of the problem, due largely to the fact that most laypeople think 'binge drinking' refers to a level of alcohol consumption well above the research definition. Compounding this problem is that the research measure fails to account for a drinking episode's length. A large man—think Falstaff—who has five drinks over a five-hour period is unwise, but his behavior hardly matches the sensationalistic label 'binge drinking.'"